ATLANTIC CROSSING **Uwe E Reinhardt**

Faith based health policy: the urge to privatise

Who owns health systems matters less than that the various enterprises are on a level playing field

Privatising publicly owned and operated enterprises in health systems has become a new fashion in health policy. The movement is based on the credo (and a pure credo it is) that the management of anything by investor owned, private enterprise is by that very fact more efficient than management of the same activity by publicly owned enterprise. Like most credos—such as the belief in the Virgin Birth—this one lacks robust empirical support; but it matters little. The believers march on undaunted and have been successful in spreading the faith.

One illustration is the firm belief of President Bush and his supporters in Congress that the long term fiscal sustainability of the hitherto government run Medicare programme for elderly people in the United States can be assured only by entrusting that programme to private health insurance plans. On the basis of that credo, they wrote into the Medicare Modernization Act of 2003 a provision under which US tax payers must now pay private health plans an average of 12% more for enrolling a Medicare beneficiary than it would have cost under the traditional, government run Medicare programme. Only faith in the inherent superiority of private enterprise could persuade anyone that such a policy would enhance the long term fiscal sustainability of Medicare—but faith carried the day.

To secularists not beholden to this faith, the intellectual challenge in thinking about the relative merits of private and public enterprise begins with the word "efficiency." In the proper usage of the word an activity is judged efficient when it attains a specified goal with the least expenditure of real resources. It follows that efficiency is merely a means to a specified end and not, as seems widely assumed, an end in itself. Indeed, unless the goal to be achieved by a human activity is clearly specified, the word "efficiency" loses its practical meaning.

In determining the goals of a nation's health system one consideration is the degree to which individuals' experience of health care should be allowed to vary by income and, furthermore, whether or not their payment for health insurance should depend on their health status. Thus, when health policy analysts and the policy makers whom they serve declare private enterprise to be more "efficient" than public enterprise in health care, they should immediately be challenged to demonstrate that either form of ownership will obey the same distributive ethic in health care. If not, the discussion should promptly shift from relative "efficiency" to the relative social merits of the different distributive ethics obeyed by the two forms of enterprise.

In such a discussion, it will be useful to distinguish between the ownership and control of healthcare delivery and the ownership and control of healthcare financing. It is mainly through the ownership and control of financing that society expresses its ideas about the distributive social ethic that should govern its healthcare system.

Nations that seek to divorce the individual's healthcare experience in the case of a given illness from the person's socioeconomic status—and moreover that wish to base the individual's contribution to the financing of health care on ability to pay rather than the individual's health status—will find an adequately financed, single payer, government run health system to be the ideal insurance mechanism to attain that goal. However, the government can, as Germany has shown, approximate the same degree of horizontal equity through tight regulation of multiple insurance carriers. In such systems it matters little who owns and operates the delivery of health care. As long as investor owned healthcare facilities that are run for profit are forced to compete with government owned or community owned non-profit enterprises in the face of the very same payer—and under identical rules and payment levels—both forms of healthcare facility will be forced into similar behaviour. In fact, in such systems it may be desirable to have different ownership models compete with one another over clinical quality and patients' satisfaction.

"A market driven health system will leave a sizeable segment of the population without the benefits of health insurance"

By contrast, in a market driven health system in which both healthcare delivery and health insurance are entrusted to the hands of investor owned enterprises, people's socioeconomic and health status will inevitably influence their healthcare experience. A distinguished literature in economics shows that private health insurers competing in an unregulated market will inexorably segment their clientele into risk classes, with prospectively sicker people being charged much higher, "actuarially fair" insurance premiums than prospectively healthier people. As has been shown in the United States for over half a century now, such a system will also leave a large segment of the population without the benefits of health insurance.

Forthright economists agree with the late Milton Friedman's dictum that the proper goal of investor owned, private enterprise is to run the affairs of the firm so as to maximise the owner's wealth, without breaking the laws of the land. The stock market in general, and private equity buyout firms in particular, make sure that managers pursue that singular goal with utter devotion. But their energy and ingenuity will also serve society's larger goals—such as a particular distributive ethic in health care—only if that energy and that ingenuity are constrained to that end by appropriate laws, rules, and payment systems. It is on this facet of health systems that the critics of privatisation should focus their scrutiny, rather than on patterns of ownership themselves.

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MEDICINE AND THE MEDIA

The dangers of triage by television

The much criticised "win a kidney" gameshow may have turned out to be a hoax that was later hailed as a "fantastic stunt," but that still doesn't justify it, write **Inez de Beaufort** and **Frans Meulenberg**

"Shameful," "Disgusting," and "An idea so sickening: it must stem from Holland"—these were some of the headlines on 25 May, the day the Netherlands' BNN Broadcasting Company announced its *Big Donor Show*. The idea of the programme was that a terminally ill woman, 36 year old Lisa, would talk live in the studio with three pre-selected young patients, all in need of a kidney. Then she would choose which of them would receive her kidney before her death. Viewers would be able to advise her via SMS messages.

Predictably, news of the show provoked a worldwide storm of moral disgust: "Outcry over TV kidney competition," reported the BBC, while the *New Zealand Herald* referred to "Organ Idols." When the programme was broadcast on 1 June, 1.2 million people tuned in, 23 000 "voted," and 50 000 people downloaded or ordered a donor-registration form.

The founder of BNN, one of the Netherlands' public networks, died from kidney disease in 2002, after two transplants. Defending the show, BNN's chairman said, "We know that this programme is super-controversial and . . . that some people will find it tasteless, but we think the reality is even more shocking and more tasteless."

But indignation reigned. The public for the most part (61%, according to a poll) was against the show. The Dutch minister of education, culture, and media, Ronald Plasterk, said he disliked the "competition element." The transplantation centres stated that the programme makers had not contacted them. The Royal Dutch Medical Association advised doctors not to cooperate, saying, "People's sufferings should not be the topic of an amusement show." The Kidney Foundation reacted cautiously, saying the programme makers "encourage initiatives that lead to more discussion on organ donation . . . but the format—a show programme—would very certainly not be our choice."

Only a few hours before the broadcast, Dutch prime minister Jan-Peter Balkenende expressed his regret and worries about "the Dutch image abroad."

Background

In the Netherlands, which has a voluntary registration system for postmortem donation, people can register as donors, they can refuse donation, or they can register for others to decide on their behalf. Out of a population of 12 million adults, 2.8 million people are registered as potential organ donors.

Every year hundreds of people die because of the lack of an organ. On 1 May 2007, 1049 people were on the waiting list for a kidney from a postmortem donor; 151 were on the list for a liver and 144 for a lung transplant. However, in 2006 only 360 kidneys, 83 livers, and 52 lungs became available from deceased donors; 274 kidneys were given by living donors. One in three people on the waiting list dies without having had a transplant. Besides a declining willingness to donate, there is also the problem of family members who refuse donation when the deceased has left the decision to them or made no arrangements on the matter (280 refusals out of 398). Several government campaigns to increase the number of organ donors have not resulted in the availability of enough organs.

What are important arguments in the debate?

There is no law against bad taste and the notion of impropriety is notoriously difficult to pin down. But impropriety has to do with witnessing private moments that are "none of your business" (for example, to publish the pictures of Princess Diana after her road crash), and with people publicly being put in embarrassing or humiliating situations.

Pleading for yourself publicly in a matter of life and death is degrading. To be manoeuvered into such a position implies deep desperation and an ensuing willingness to do anything, including advertising one's personality to a sensation-greedy public. But as the candidates in *The Big Donor Show* autonomously agreed to participate, doesn't that "undo" the impropriety? People can compete for the oddest goals and in the oddest situations on television, so why not for a kidney? Don't desperate situations justify desperate measures, as the argument of BNN ran? No. One could still argue that people shouldn't be put into this situation and they should be protected against such an exhibition. Not only was the dignity of the candidates at stake, but also that of the audience. Was this not a modern version of the freak show, rejoicing in the circus of the needy? Impropriety attracts attention.

Nothing personal?

The show also thrived on the idea that people enjoy having power over others, even in life or death, and love to decide the fate of their fellow men. As the public (23 000 of them) sent messages naming their preferred candidate, all too eager to assist Lisa in her God-like role, they apparently knew who deserved the kidney.

Of course we all pass judgments on each other. But in the realm of medical scarcity, allocation criteria should be relevant for the treatment in question, and public popularity based on "X factor" charm and eloquence is unrelated to the need for a transplant. There are unattractive, uninteresting people with no media X factor desperately needing a transplant. They should have equal access and be able to trust the fairness of the allocating system. Not to have a transplant because of bad luck, or the bitter arbitrariness of fate, is hard to cope with, but it is even more cruel to be rejected because the public inquisition weighed you and found you wanting.

The slippery slope

If the selection for kidneys can be turned into a spectacle, where does it end? Will there be an increasing industry of shows, games, and lotteries to perform triage for scarce medical resources? Who is the best mother whose baby deserves to be on the ventilator? Who wins a bone marrow transplant for his child? "Temp-

VINCENT JANNINK/AFP PHOTO

tation Transplant Island," "Dancing with Stars for Hip Transplants"? Slippery slope arguments must be used with caution. One has to argue why a slope would indeed be slippery and why it would be a realistic scenario. In this case the argument seems convincing: the fact that so many people watched and participated in the "voting" is telling *and* worrying.

The apotheosis

Just as Lisa was about to reveal who would get her kidney, the host of the show stopped her and revealed that "Lisa" was Leonie, an actress, in perfect health and not donating a kidney. The three candidates were real patients who had known all along that this was a stunt. The aim of the programme was to draw attention to the scarcity of organs.

So, the controversial "show" was a hoax, a publicity campaign. Immediately after the show Minister Plasterk said that it was "a fantastic stunt." But is it? Three mechanisms proved to be effective: the medium of television, the personification of the problem, plus the sense of moral outrage. Evoking the latter was especially impressive. But the show's long term effect remains to be seen. Will more people register? Will they donate as living donors? According to one newspaper, six people volunteered as living donors right after the show. But the programme could have the opposite effect: people could feel they were fooled, and turn their back on the issue of organ donation. Certainly BNN stressed the need to keep the scarcity of organs high on the political agenda.

We wonder: those who watched the programme and felt a preference for one of the candidates: are they ashamed? We were (and we watched only for the purposes of writing this article).

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MEDICINE AND THE MEDIA

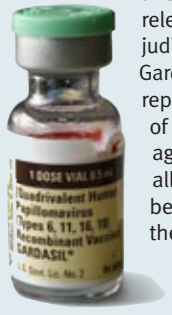
Fainting schoolgirls wipe $A1bn off market value of Gardasil firm

Simon Chapman and Ross MacKenzie

On 22 May news broke that 25 girls at a Catholic high school in Melbourne who had just had their first injection of Gardasil, the vaccine against human papillomavirus (HPV), presented to the school's sick bay with symptoms that included headache, nausea, and dizziness. CSL, the vaccine's Australian developer, reports that four pupils were sent to hospital for further examination. It said, "One had chest pain and palpitations; she had a past history of these symptoms. She was discharged the same day. The second had hyperventilation paraesthesiae and was sent home the same day. The third and fourth had neurological symptoms and were admitted. The fourth girl had reported progressive muscular weakness. Overnight both got better and were seen by the neurologist in the morning who diagnosed non-organic illness."

Other than the mother of one girl, who dismissed suggestions of the episode's psychogenic origin as "absolute rubbish" during a television interview, no one has since disputed this summary. The Royal Melbourne Institute of Technology's Stephen Downes argued in the Australian online media service Crikey that the incident indicated "mass sociogenic illness" (www.crikey.com.au, 28 May, "Gardasil, nausea and the power of the mind"), the medical euphemism for mass hysteria, whereby contagion transmits by "line of sight," rumour, and anxiety (*Drug Safety* 2003;26:599-604).

As news coverage of the incident took off (24 reports in Australian national and state capital newspapers between 23 and 31 May and eight television reports), the stock price of CSL, which had unfalteringly doubled in a year, began to dive—from $A96.67 (£41; €60; $81) to $A87.31 by 1 June), wiping an estimated $A1bn off the company's market capital. The swift market reaction was possibly boosted by publicity of claims on a US "you can't trust government" website, Judicial Watch, that Gardasil was implicated in three deaths in the United States (www.judicialwatch.org/6299.shtml). A quotation in the article from the president of Judicial Watch set the tone: "The FDA [US Food and Drug Administration] adverse event reports on the HPV vaccine read like a catalog of horrors." However, the FDA's reports on two of the three cases found that significant pre-existing health problems were relevant in each death (www.judicialwatch.org/archive/2007/GardasilVAERSDeaths.pdf). The report on the third death, that of a female patient of unknown age who died from thrombosis allegedly "three hours after being vaccinated," contained the clarification that the patient had not been vaccinated by the reporting agency. Investigations into whether she had in fact ever been vaccinated continue.



Sombre television reports in Australia repeatedly recycled the same footage of a Melbourne girl who was said variously to have "totally collapsed," been "temporarily paralysed," had her "legs and arms paralysed," or had been "left paralysed for six hours." The rapidly recovered girl's claim on national television that her classmates had been "dropping like flies" was repeated in four bulletins. Medical and government authorities who were interviewed consistently explained the incidents as commonplace anxiety reactions to vaccination.

Gardasil has attracted opposition from extreme elements on the religious right, who argue that it might encourage adolescent sex, and a number of Australian schools have refused to administer the vaccination (www.news.com.au/dailytelegraph, 23 May, "Promiscuity fears killing a lifesaver"). Christian promoters of the "virginity pledge" have been joined in their opposition by the ever vigilant antivaccination lobby, which opportunistically opposes all vaccines, and by a self declared feminist duo comprising an anti-abortionist and a founder of the now defunct Feminist International Network of Resistance to Reproductive and Genetic Engineering, whose opinion piece in the Melbourne *Age* referred readers to the official sounding United States National Vaccine Information Center, a citadel of antivaccinationist advocacy (www.theage.com.au, 25 May, "Why are we experimenting with drugs on girls?").

Interest groups with a variety of agendas can amplify trivial incidents into major news stories (*Epidemiologic Reviews* 2003;27:107-14), undermining public confidence in vaccines, diverting the efforts of public health authorities, bringing about serious share market reactions, and, occasionally, resulting in confused or risk averse local government and educational authorities suspending their support. In the field of tobacco control the tobacco industry's highly orchestrated public efforts over decades to dissemble the risk of smoking (*BMJ* 2000;321:371-4) has now virtually disappeared, thanks to major efforts at exposing and discrediting this "vector" for public disinformation. Public health officials would do well to give the same sort of serious attention to researching the nature of the anti-immunisation "vector" for disrupting national vaccination campaigns (*Australian and New Zealand Journal of Public Health* 1998;22:17-26).

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Competing interests: SC owns 150 shares in CSL.

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